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Advocating for Smarter Medicine: Swiss experience and an international comparison of methods for creating Top 5 lists

Introduction

In 2010, in the midst of American health care reform and an increased focus on ‘too much medicine’, a movement was created to have physicians acknowledge their role in creating medical waste [1,2]. The idea was put forward of ‘top 5’ lists of expensive diagnostic tests or treatments to be avoided because of no “meaningful benefit to at least some major categories of patients for whom they are commonly ordered” and the National Physician’s Association of the United States launched a grassroots process to identify such activities, using a physician-led committee [3]. The *Choosing Wisely* campaign of the American Board of Internal Medicine was created, and now includes more than 70 participating medical societies, some of which contributed to more than one Top 5 list [4]. This work was similar to the existing work of the National Institute of Health and Clinical Excellence (NICE) that had been accumulating ‘Do Not Do’ recommendations since 2009 in the UK [5].

The issue of unnecessary medical care is not limited to the United States and the UK, and there has been widespread interest in other countries to address overuse and replicate these campaigns [6]. In 2012, the Swiss Academy of Medical Sciences published a report examining ways to make the Swiss healthcare system more sustainable, and in it called on medical societies to replicate the Top 5 lists of the *Choosing Wisely* campaign. At its annual meeting in September 2012, the Swiss Society of General Internal Medicine (SSGIM) committed itself to addressing overuse, and designated a committee to create a list of healthcare activities to be avoided in ambulatory general internal medicine.

Swiss experience creating a Top 5 list

Under the direction of the society’s president, a committee was created by the SSGIM to guide the process of creating a list of low value healthcare activities to draw attention to waste in healthcare [7]. As previously published [8], the committee began by identifying three existing international sets of lists as of early 2013. An online Delphi process was then used by 35 experts in general medicine who completed with successive electronic survey surveys presenting the existing recommendations and allowing the possibility of providing new recommendations. They then ranked the recommendations based on overall agreement, the second time incorporating feedback from earlier rounds. The agreement scores were relatively high, with an average of 8.52 out of 10 (SD ±0.80). For round 3, recommendations with average scores greater than 9 were scored based on a 3-point Likert scale in 3 areas: frequency, costs, and patient harm. In order to ensure a list that was balanced between different areas, the final list was limited to 5 of the 10 most frequent recommendations. The detailed list is available in English, as well as the 3 official languages of Switzerland, French, German and Italian, at www.smartermedicine.ch. Each item contains a clarification statement and the level of evidence supporting the recommendation.

Summary of implementation to date and next steps in Switzerland (Table 1): The presentation of the first Top 5 was made at the SSGIM annual conference in May 2014, as part of the launch of *Smarter Medicine*, the name given to the Choosing Wisely campaign in Switzerland. The list was presented at the same time in local medical journals and was reported in several leading Swiss newspapers and news stations in German, French and Italian.

On the local level, the elements of the SSGIM Top 5 list are being integrated into all levels of medical education, from pre-graduate to continuing medical education (CME). In Lausanne, for example, the list is incorporated into the medical school curriculum for general medicine, encouraging medical students to be critical thinkers. There have been numerous CME conferences about the topic throughout the country, most notably at general medicine conferences: the 5 most recent conferences have included 11 sessions to discuss and promote the Smarter Medicine campaign.

In the domain of research, the SGIM Foundation called in 2014 for proposals of projects related to the themes of “can less be more?” and overdiagnosis. One of the two projects funded is measuring the acceptability of the Top 5 lists among Family physicians in a research network, their self-reported current practices concerning the 5 items, and the reasons why they may sometimes feel the need to go against the recommendations (ex: patient insistence leading to antibiotic prescription, or lack of time of physicians to prostate cancer screening without a discussion with the patient). Outside of these efforts, there has been considerable attention paid to the theme “too much medicine” in Swiss journals across multiple specialties.

The SSGIM released a second Top 5 list for hospital-based General Internal Medicine in spring 2016 [9], and there was a national conference held by the National Academy of Medical Sciences in November 2015 to encourage other professional societies to do the same and an international conference in September 2015 in Lugano as part of the Choosing Wisely International movement.

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Table 1
Smarter Medicine campaign stages.

Stage	Date	Comments
1. Call to action	Nov 2012	Swiss Academy of Medical Sciences report "Sustainable medicine", followed by the commitment of the Swiss Society of General Internal Medicine (SSGIM)
2. Selection of Top 5 list	Feb 2013 to Jan 2014	Creation of a steering committee that guided the process detailed above
3. Creation of website and media materials	Early 2014	Choice of campaign name *Smarter Medicine* to avoid confusion with rationing care and to distinguish between local and American efforts. Primary materials created in German and French
4. Announcement and dissemination of list	May 2014	Announcement at SSGIM annual meeting given in conjunction with the European Congress of Internal Medicine
5. Publication of methodology	Feb 2015	Methods, results and conflict of interest statement published in *JAMA Internal Medicine* [8]
6. Incorporation into teaching	May 2014-ongoing	No centrally created curriculum, but local efforts are underway to integrate the Top 5 list into undergraduate, graduate and continuing medical education
7. Evaluation of list by practitioners	Sept 2015- ongoing	SSGIM-mandated project underway to evaluate the acceptability and practicability of the Top 5 list for primary care physicians
8. Creation of a second list for hospital internal medicine	May 2016	The SSGIM has creating a second list for hospital-based Internal Medicine
9. Interest from other Swiss societies	Ongoing	There was a meeting held by the Swiss Academy of Medical Sciences to help generate interest from other specialty organizations. The Swiss Society of Paediatrics is particularly interested

SSGIM: Swiss Society of General Internal Medicine

Table 2
Comparison of methodology used to develop Top 5 lists in General and Internal Medicine, listed chronologically.

Country	Year	Society	Elements to methodology for developing list						
			Selection method	Published criteria for items	Explicit use of previous lists	Choice of experts	Public forum for feedback	Field-testing with practitioners	Conflicts of interest statement
United States of America	2012	National Physicians Association [3]	Nominal group process	Yes	No	Selection after email solicitation of members	No	Evaluated by 173 family MDs	Reported in publication
		American Academy of Family Medicine (items 6-15) [4]	Approval by leadership	Yes	No	Not specified	No	No	Link to society statement
		Society of General Internal Medicine [4]	Committee vote	Yes	No	Ad hoc committee of society members	No	No	Link to society statement
		Society of Hospital Medicine [4]	Delphi method	Yes	No	Subcommittee, with vote by all members	No	No	Link to society statement
Italy	2013	Società Italiana di Medicina Generale [13]	Discussion by members	No	Yes	Committee from local section of Society	No	No	Not specified
Netherlands	2014	Dutch Association of Internal Medicine [14]	Discussion by members	Criteria from Choosing Wisely USA	No	Board members of sub-specialty societies	Yes	Draft items sent to all members for feedback	Not specified
Switzerland	2014	Swiss Society of General Internal Medicine – Ambulatory [8]	Delphi method	Yes	Yes	Central committee of societies and university experts	No	No	Reported in publication
		Swiss Society of General Internal Medicine – Hospital [9]	Ranking by criteria and expert consensus	Yes	Yes	Society members and chiefs of hospital departments	No	No	Not specified
Canada	2014	Canadian Society of Internal Medicine [15]	Online vote and committee consensus	Yes, for overall campaign	Yes	Committee of society members, selection not specified	Yes	No	Not specified
		The College of Family Physicians of Canada [16]	Committee decision and online vote	Yes, for overall campaign	Yes	Existing Forum of Family and General Practice committee	No	No	Not specified
Australia	2015	Royal Australian College of General Practitioners [17]	Discussion and vote by all members	Yes	No	'Working group', selection not specified	Yes	No	Not specified
Japan	2015	Japan Primary Care Association [18]	Delphi method	Not known	Yes	Expert committee from Society members	No	No	Not known
Germany	2015	Association of the Scientific Medical Societies [19,20]	Delphi method	Yes	No	Ad hoc committee of society members, external experts and one patient representative	No	No	Reported in publication

Methodology used in other countries: In Table 2 we compare the methods used to create Top 5 lists by professional societies in Family and General Internal Medicine internationally. A literature search revealed thirteen lists; three campaigns, in Wales, the larger United Kingdom, and New Zealand are mentioned in the literature as having lists in progress, but were not publicly available at the time of this article.

Examining the methodology used to create these lists brings up several important points. First, choices are most often made by expert committees made up of senior members of the respective professional society, rather than by a systematic review process, allowing for more appropriate choices that are tailored to the local context [10]. Second, most international societies choose to build on existing international lists, much as we did in Switzerland. Third, the triage of possible recommendations is typically made using consensus techniques, such as the Delphi method. Taken together, these three elements form a pragmatic methodology that is appropriate for a spontaneous, rapidly expanding, grassroots movement like Choosing Wisely. However, this approach could introduce important limitations to the selection process. First, consensus techniques are criticized for forcing consensus, generating quantitative results without strong underlying evidence, and producing limited reproducibility. Second, while there are typically publicly-available criteria used for selection, the combination of consensus techniques and an ad-hoc choice of experts can make it difficult to judge the final choice against these criteria. For instance, there has been some criticism that professional societies have avoided activities that bring them significant revenue, preferring instead to focus on either rare procedures or peripherally associated items more commonly performed by other specialties such as family medicine [11].

In response, the Choosing Wisely movement may be able to borrow from the criteria used for the creation and evaluation of clinical guidelines, such as ensuring broad stakeholder involvement, disclosure and management of conflicts of interest, and transparency when judging the level of evidence that supports recommendations. Such an approach could avoid many of the pitfalls of guidance based solely on the opinion of a small number of experts. Another possibility would be to consistently publish or validate lists prior to final publication, as the National Physician's Association did for the original Top 5 lists [3]. These steps could help to avoid later backlash, as occurred within the Society of General Internal Medicine in the US for the recommendation to no longer perform "routine general health checks for asymptomatic adults". The methodology used by the American College of Emergency Physicians has been highlighted, as they based themselves on existing work, surveyed their entire membership, included available cost data in their review of the literature, and made their panelists' conflict of interest statements publicly available [12].

Conclusions: As physicians, we must acknowledge that some commonly performed low-value activities should be avoided. Going forward, the *Smarter Medicine* Campaign is leading an evaluation of the Top 5 list and the inclusion of other professional societies from Switzerland. There are common elements to the selection process of Top 5 lists in General Internal Medicine and Family Medicine internationally, such as the dependence on a group of experts, explicitly using items from other lists internationally and the use of consensus methods to find common ground. While early reports of the impact of the Top 5 lists on patient care are conflicting, we hope that they will raise awareness in Switzerland and abroad that more is not always better.

References

[1] Brody H. Medicine's ethical responsibility for health care reform–the Top Five list. N Engl J Med 2010;362(4):283–5.

[2] Carter SM, et al. The challenge of overdiagnosis begins with its definition. BMJ 2015;350:h869.

[3] Good Stewardship Working Group. The "top 5" lists in primary care: meeting the responsibility of professionalism. Arch Intern Med 2011;171(15):1385–90.

[4] American Board of Internal Medicine Foundation. Choosing Wisely. 2013 March 18, 2016]; Available from: http://www.choosingwisely.org/.

[5] National Institute of Health and Clinical Excellence. NICE 'do not do' recommendations. 2013 18 march, 2016]; Available from: https://www.nice.org.uk/savingsandproductivity/collection?page=1&pagesize=2000&type=do%20not%20do.

[6] Levinson W, et al. 'Choosing Wisely': a growing international campaign. BMJ Qual Saf 2015;24(2):167–74.

[7] Regard S, Gaspoz JM, Kherad O. ["Less is more"]. Rev Med Suisse 2013;9(381):770, 772-4.

[8] Selby K, et al. Creating a list of low-value health care activities in Swiss primary care. JAMA Intern Med 2015;175(4):640–2.

[9] Sabine Bavamian GL, Kherad O, Rodondi N, Rutishauser J, Waeber G, Meier C. Vers une pratique en médecine interne hospitalière plus performante. Primary Care 2016;16(13):243–5.

[10] Garner S, et al. Reducing ineffective practice: challenges in identifying low-value health care using Cochrane systematic reviews. J Health Serv Res Policy 2013;18(1):6–12.

[11] Morden NE, et al. Choosing wisely–the politics and economics of labeling low-value services. N Engl J Med 2014;370(7):589–92.

[12] Grady D, Redberg RF, Mallon WK. How should top-five lists be developed?: What is the next step? JAMA Internal Medicine 2014;174(4):498–9.

[13] Italian Society of General Medicine. *Fare di più non significa fare meglio*. March 18, 2016]; Available from: http://www.slowmedicine.it/pdf/Pratiche/scheda%20SIMG.pdf.

[14] Dutch Association of Internal Medicine. *Wise Choices in Internal Medicine*. 2014 02.08.2016]; Available from: http://www.kwaliteitskoepel.nl/verstandig-kiezen/english/?ins_rd=d3d3LmNob29zaW5nd2lzZWx5bmV0aGVybGFuZHMub3Jn.

[15] Canadian Society of Internal Medicine. Five Things Physicians and Patients Should Question. 2014 March 23, 2016]; Available from: http://www.choosingwiselycanada.org/recommendations/internal-medicine/.

[16] The College of Family Physicians Canada. Eleven Things Physicians and Patients Should Question. 2014 March 23, 2016]; Available from: http://www.choosingwiselycanada.org/recommendations/family-medicine/.

[17] The Royal Australian College of General Practitioners. Tests, treatments and procedures clinicians and consumers should question. 2015 March 23, 2016]; Available from: http://www.choosingwisely.org.au/recommendations/racgp.

[18] Tokuda Y. Current Status of Choosing Wisely in Japan. General Medicine 2015;16(1):3–4.

[19] Nothacker M, G.W., Gogol M, et al. Manual Entwicklung von Empfehlungen im Rahmen der Initiative Gemeinsam Klug Entscheiden (GKE). Marburg: Arbeitsgeminschaft der Wissenchaftlichen Medizinischen Fachgesellschaften; 2015.

[20] Hasenfuss G, et al. [Choosing wisely in internal medicine]. Internist (Berl) 2016;57(6):521–6.

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